STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445320	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	4081 THORNTON TAYLOR PARKWAY FAYETTEVILLE, TN 37334

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F 000	INITIAL COMMENTS Complaint # 39462, #40106, and #40116 were completed at Fayetteville Health and Rehabilitation Center on 12/7/16. Deficiencies were cited under 42 CFR Part 483 Requirements for Long Term Care Facilities.	F 000	**"This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction, Fayetteville Health and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that forms the basis for the deficiency."**	
F 223 SS=D	483.12 FREE FROM ABUSE/INVOLUNTARY SECLUSION 483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility placed 1 (Resident #2) resident of 4 residents reviewed inside the secured unit against his will. The facility failed to provide a least restrictive alternative for the resident prior to being secluded from his room and familiar residents. The findings included: Review of a facility policy titled Abuse Prevention/Reporting Policy and Prevention dated 2013 revealed, "...Residents must not be subjected to abuse by anyone...Abuse is defined as...unreasonable confinement...separation of a resident against the resident's will...When a resident is secluded for more than 1 hour the following must be documented in the resident's	F 223	**F223 Free from Abuse/Involuntary Seclusion** 1. Resident #2 was discharged from the facility on 12/2/16 after he was sent to the local hospital and was then transferred to geriatric psych for inpatient admission and treatment. 2. All residents have the potential to be affected by the deficient practice. On 12/22/16, a 100% audit of all residents on the secured unit were completed by the Director of Nursing and Administrator to ensure the residents had an appropriate diagnosis of Dementia and that no resident was involuntarily secluded. There were no residents involuntarily secluded at the time of that review. From 12/9/16 to 1/6/17, the staff were re-educated on the facility abuse policy and procedure by the Director of Nursing and/or Unit Managers specifically related to involuntary seclusion, alternative interventions, and documentation requirements. The nursing staff were also educated during that time that they must notify the on-call nurse and/or	1/6/17

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Vitatoe | TITLE: Administrator | (X6) DATE: 1/10/17

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that :her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ·ogram participation.

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F 223	Continued From page 1 medical record: 1. The symptoms leading to the seclusion. 2. The root cause of the symptoms...3. Alternative interventions prior to the seclusion..." Medical record review revealed Resident #2 was admitted to the facility on 8/19/16, readmitted on 11/30/16 and discharged on 12/2/16 with diagnoses including Diabetes Mellitus type II, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, Depression, Chronic Kidney Disease, Parkinson's, and an Adjustment Disorder with Depressed Mood. Continued review of a 14 day Minimum Data Set dated 11/9/16 revealed the resident had disorganized thinking that fluctuated daily, had no behaviors, and did not wander. His Brief Interview for Mental Status score was 11/15 indicating moderate cognitive impairment. The resident required limited assistance of 1 person transfers, had no extremity impairments, and used a wheelchair for ambulation throughout the facility. Medical record review of the Risk of Elopement/Wandering Review assessment revealed on 8/19/16, 10/26/16, 11/10/16. and 11/30/16 Resident #2 was assessed as not at risk for elopement/wandering at this time. Continued review revealed documentation on 11/10/16 of "...voices desire to go home but is aware of need for therapy services..." Review of a facility investigation dated 9/29/16 revealed Resident #2 stated, "...that he was sitting at the door of the locked unit trying to figure out the code to the door..." Continued review revealed, "...The resident is alert and oriented x (times) 3 with some confusion noted at times...The facility does have video cameras in	F 223	Director of Nursing before moving any resident from their current room and/or routine environment even if the change is temporary. 3. The facility staff were re-educated by the Director of Nursing and/or Unit Managers from 12/9/16 to 1/6/17 on the facility abuse policy and procedure specifically related to involuntary seclusion, alternative interventions, and documentation requirements. The nursing staff were also be educated during that time that they must notify the on-call nurse and/or Director of Nursing before moving any resident from their current room and/or routine environment even if the change is a temporary change. The Unit Manager and/or Director of Nursing will maintain a log of room and/or environment changes, even if the change is temporary, ongoing with the reasons why the change was necessary and alternative methods attempted. 4. The log of room or environment changes will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) Committee by the Director of Nursing and/or Administrator ongoing. The QAPI Committee will then determine if any further actions, systematic changes, or monitoring is needed to assure sustained compliance.	

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F 223	Continued From page 2 the hallway...it was very clear by reviewing the camera by the locked unit door...the resident was not combative in any way...The resident was viewed self-propelling his wheelchair back into and back up the hallway..." Continued review revealed the facility reviewed the video from 2:00 PM- 4:00 PM of the resident in the secured unit hallway and at the locked door. Review of a telephone statement made by Licensed Practical Nurse (LPN) #1 on 9/29/16 revealed on 9/18/16 another nurse reported to her the "...pt. [patient] was sitting at doorway which is not unusual." The weekend supervisor "...came to memory lane [secured unit] and stated [Resident #2] is trying to get out of the door. [LPN #1] then spoke with patient and took him to memory lane so he could be watched closer. He stayed in the back until his family arrived and they visited with him in his room...This was the 1st behavior episode that this nurse had been involved in with this patient." Telephone interview with LPN #1 on 12/6/16 at 12:30 PM revealed the LPN confirmed her written statement after it was read to her by the surveyor. The LPN confirmed she had taken Resident #2 to the secured unit after a nurse and the supervisor told her he was exit seeking. The LPN stated the nurse worked PRN (as needed) and the supervisor was new and neither one knew the resident sat at the door frequently. Continued interview revealed the LPN was caring for residents on the secured unit as well as residents on the unsecured unit and she placed Resident #2 in the secured unit so she could visualize him better. When asked if the resident wanted to be in the secured unit the LPN stated, "He was upset at first and was ranting and raving and yelling that	F 223		

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F 223	Continued From page 3	F 223		

he wanted to call the cops. When I asked him why, he said because you got me back here." The LPN stated she told the resident "I can't watch you if you get outside and roll down the hill into the road." The nurse stated, "His family came to visit shortly after that, and they took him back to his room (unsecured unit) to eat lunch. When they were done visiting the family brought him back to me in the secured unit." Continued interview revealed the LPN stated the time frame was approximately 1:30 PM to 5:30 or 6:00 PM. During this time was when the resident was visualized on the video camera in the hallway by the door banging on it and pushing the buttons to try to get out. 2 PM-4 PM was quiet time for the resident's who lived in the secured unit. The LPN reported she explained that to the resident and encouraged him to take a nap in an empty room which he did for 45 minutes. The LPN was asked if she offered to take the resident outside and she stated, "I don't remember him going outside."

Medical record review revealed no documentation regarding the root cause of the symptoms that caused the resident to want to go outside, and no alternative interventions prior to placing the resident in the secured unit were found.

Interview with the Director of Nursing (DON) on 12/6/16 at 12:45 PM in the Admission's Office confirmed Resident #2's room was #126 A and was not located in the secured unit. Continued review revealed the DON stated "he tried to follow family out the door so the nurse put him in Memory Lane for a couple of hours. I personally didn't think he was trying to leave the grounds. I think he wanted to go outside cause he liked to sit outside." The DON was asked if anyone offered to take the resident outside, or sit with him, and

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F 223	Continued From page 4 the DON stated, "I don't know, but we have hospitality aides here now, and Activities is here on the weekends too." The DON confirmed no other interventions were attempted prior to placing Resident #2 in the secured unit against his will. The facility failed to protect the resident from involuntary seclusion.	F 223	**F241 Dignity and Respect of Individuality** 1. The torn floor mat for Resident #4 was replaced by the Housekeeping Supervisor on 12/7/16. Resident #4 was hospitalized on 12/8/16 due to continued diarrhea and weakness. She was re-admitted back to the facility on 12/11/16 in the room she was in prior to the order for contact isolation due to she returned to the facility without any orders for further contact isolation. On 12/11/16, the Unit Manager ensured that all of her personal belongings which included her television, clothing, pictures, and any other décor had been cleaned and moved back to the room where the resident was residing. Upon readmission to the facility, the resident was no longer placed on a mattress on the floor due to no further falls having occurred since isolation was discontinued. 2. All residents have the potential to be affected by the deficient practice. An audit was conducted on 12/12/16 by the Director of Nursing and/or Administrator to identify if resident rooms had personal items displayed, if mattresses were on the floor, and if any floor mats were torn. Any issues identified were immediately addressed and items replaced if necessary.	1/6/17
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide an environment that promoted and enhanced the dignity for 1 (Resident # 4) resident of 4 residents reviewed. The findings included: Medical record review revealed Resident #4 was admitted to the facility on 5/6/09 and readmitted 10/28/16 with diagnoses including Paranoid Schizophrenia, Dementia with Behaviors, Parkinson's, History of Falls, Delirium, Anxiety, Depression, and was placed on Contact Isolation for diagnosis of Clostridium Difficile on 10/5/16. Continued review of a 14 day Minimum Data Set dated 11/11/16 revealed the resident was severely cognitively impaired, required extensive assistance of 2 people for bed mobility, transfers, hygiene and toileting, was unsteady on her feet,	F 241		

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F 241	Continued From page 5 and only able to stabilize herself with assistance from staff, and was occasionally incontinent of bowel and bladder. Observation of Resident #4 on 12/7/16 in room 140 A at 8:45 AM revealed the resident was alert, laying on her back on a mattress on the floor in a hospital gown. Her hair was disheveled, and she had a bruise to her left eyelid. A fall mat was on each side of the mattress. The mat on the left side of the resident was torn in 3 places with dark brown saturated debris visible. A small pink plastic water pitcher and a small clear plastic cup was at the head of the bed to the right of the resident. A straight back chair and an over bed table were in the far corner of the room as well as a small table with a small TV on it. The call light was to the left of the resident on the floor. The resident attempted to get up off the mattress and she was not wearing any briefs and there was no pad underneath her on the mattress. Continued observation revealed there were no personal items, pictures on the walls, or decor of any kind in the room. Resident #2 was asked if she was still having diarrhea and she stated, "Yes." When questioned about the bruise to her eye, she stated, "I don't know." Interview with Licensed Practical Nurse (LPN) #2 on 12/7/16 at 9:00 AM in the Memory Lane Nurse Station revealed the bruise was found yesterday and was under investigation. Continued interview with the LPN revealed the resident could not walk on her own, but would "scoot or crawl, but that's about it." Interview with the Director of Nursing (DON) on 12/7/16 at 10:40 AM in the resident's room confirmed the resident had no personal items,	F 241	3. The facility staff were be re-educated from 12/29/16 to 1/6/17 by the Director of Nursing and Unit Managers on the facility policy on Dignity with emphasis on promoting dignity and respect for those residents who are in isolation. This education included making sure they have their personal items and décor in their room while they are on isolation precautions. When a resident is placed on isolation, within 24 hours, the Unit Manager and/or Director of Nursing will complete an observation audit ongoing of the resident room to ensure the resident's personal items and décor is present and that no dignity issues exist due to the isolation. 4. The results of the observations audit will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) Committee ongoing by the Director of Nursing and/or Administrator. The QAPI Committee will then determine if any further actions, systematic changes, or monitoring is needed to assure sustained compliance.	

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F 241	Continued From page 6 pictures or decor in her room and confirmed the dirty torn fall mat. When asked why the resident had nothing of interest to focus on in her room, the DON stated, "We didn't anticipate her being on isolation this long." The DON confirmed staff had to stand over the resident when entering the room for all care, the resident was unable to move from the mattress on the floor without assistance, and crawled in the room. The DON confirmed the facility failed to provide an environment that enhanced the resident's respect and dignity.	F 241		